COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
DISCONTINUANCE NOTICE—DECEASED PERSONS

(COUNTY STAMP)

To the Representative of the Estate of:

Case number: _____

District: _____

The county department has received notification of the death of _____.

His/her CMSP coverage will be discontinued effective _____.

The regulations which require this action are California Administrative Code, Title 17, Section 1498, et seq.

Also for your information, there are no special death or burial benefits provided under the CMSP.

If there are any questions about this action, please write or telephone. We will answer your questions or make an appointment to see you in person.

Eligibility Worker	Phone	Date

REPRESENTATIVE COPY
CASE COPY